STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155072	B. WING		06/13/2012
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹		LBANY ST	
BEECH (	GROVE MEADOWS	8		H GROVE, IN 46107	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
F0000	State Licensurincluded the In Complaint IN00 This visit was investigation of IN00109515. Complaint IN00 Substantiated. Deficiencies reare cited at F20 Survey Date: J12, and 13, 20 Facility number Provider number AIM number: 1 Survey Team: Beth Walsh, Ricourtney Mujic Karina Gates, Inc. Census Bed Tysne: 18 SNF/NF: 99 Residential: 10 Total: 127	n conjunction with an f Complaint  0108327- Federal/State lated to the allegations 41 and F314.  une 4, 5, 6, 7, 8, 9, 11, 12  r: 000029 er: 155072 00275200  N-TC c, RN Medical Surveyor  ype:	F0000	The creation and submission of this Plan of Correction does not constitute an admission by the provider of any conclusion set forth in the statement of deficiencies, or of any violation regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credit Allegation and requests a Post Certification Review on or after July 11, 2012.	ot e n of ble t
	Census Payor	rype.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000029

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	of correction (155072) Tip Provider/Supplier/Clia	(X2) MULTIPLE CO A. BUILDING B. WING	00	— СОМ 06/1	e survey pleted 3/2012		
	PROVIDER OR SUPPLIER  GROVE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE  2002 ALBANY ST  BEECH GROVE, IN 46107					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE		
	Medicare: 26 Medicaid: 71 Other: 30 Total: 127						
	Residential Sample: 7						
	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.						
	Quality review completed on June 21, 2012 by Bev Faulkner, RN						

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Facility ID: 000029

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	OF CORRECTION	IDENTIFICATION NUMBER:  155072	A. BUILDING 00			COMPLETED 06/13/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		2002 ALBANY ST				
	GROVE MEADOWS				GROVE, IN 46107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0157 SS=D	483.10(b)(11) NOTIFY OF CHA	MCES					
33-D	(INJURY/DECLIN						
	,	mediately inform the					
	•	with the resident's physician;					
	and if known, not	tify the resident's legal					
		an interested family					
		ere is an accident involving					
		th results in injury and has requiring physician					
	-	gnificant change in the					
		al, mental, or psychosocial					
		erioration in health, mental,					
		status in either life					
	threatening cond						
		need to alter treatment					
		a need to discontinue an reatment due to adverse					
	•	or to commence a new form					
	·	a decision to transfer or					
	·	sident from the facility as					
	specified in §483	-					
		also promptly notify the					
		nown, the resident's legal					
	•	interested family member change in room or roommate					
		pecified in §483.15(e)(2); or					
		lent rights under Federal or					
	~ · · ·	llations as specified in					
	paragraph (b)(1)	of this section.					
	The facility must	record and periodically					
	update the addre	ess and phone number of the					
		epresentative or interested					
	family member.						
	Based on interv	view and record	F01:	57			07/11/2012
	review, the facil	lity failed to notifying			F157 Notify of Changes in		
	the physician w	hen a resident's pain			Condition		
	was unrelieved	by multiple use of			It is the practice of this facilit	v	
		d) medications for 1 of			to immediately inform the	, 	

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Event ID: 2YWV11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDDIG	00	COMPLI	ETED
		155072		LDING		06/13/2	2012
			B. WIN		ADDRESS SITY STATE TIP CODE		
NAME OF F	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
		_			LBANY ST		
BEECH (	GROVE MEADOWS	5		BEECH	I GROVE, IN 46107		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тс	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	3 residents rev	iewed for pain.			resident; consult with the		
	(Resident A)	тот роши			resident's physician; and if		
	(resident / t)				known, notify the resident's		
	Fire alice are the alice	la.			legal representative or an		
	Findings includ	ie:			interested family member wh	nen	
					there is an accident involving	g	
	The clinical rec	cord for Resident A was			the resident which results in		
	reviewed 6/8/1	2 at 10:30 a.m.			injury and has the potential f	or	
					requiring physician		
	The diagnoses	for Resident A			intervention; a significant		
	_	vere not limited to:			change in the resident's		
	· ·				physical, mental, or		
	•	acture, back pain, and			psychosocial status; a need		
	hip pain.				alter treatment significantly;	or	
					a decision to transfer or		
	The April, May	, and June Physician's			discharge the resident from	the	
	Orders indicate	ed an order to take 2			faculty as specified in		
	tablets of aceta	aminophen 325 mg			483.12(a).		
		mouth, every 6 hours				, ,	
	, , ,	ed) for mild pain or			1. What corrective action	` '	
	,	•			will be accomplished for tho		
	temperature gr				residents found to have been	1	
		Physician's Orders for			affected by the deficient practice?		
		I June also indicated			practice:		
	an order for 1 t	ablet of ibuprofen 400					
	mg to be given	every 4 hours PRN for					
	headache. Als	o, there was an order			Resident A's physician was		
	on the April, M	,			notified of the multiple uses of		
	· ·	ders that indicated that			PRN pain medication. Physicia		
					orders will be followed. Pain		
		Reliever Plus (no			assessment was completed fo	or	
	-	ed) was to be taken by			this resident.		
	mouth every 8	hours PRN for					
	headaches.						
	The following of	lates on the April, May,			2. How will you identify		
	and June MAR	•			other residents having the		
		•			potential to be affected by		
		Record) indicated that			these same deficient practice		
	i acetaminopher	n (650 mg) was given:			and what corrective action w	rill	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	A. BUILDING 00 COMPL		
		155072	A. BUI B. WIN			06/13/2012
		1	S. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF P	ROVIDER OR SUPPLIE	R			LBANY ST	
BEECH (	GROVE MEADOWS	8			H GROVE, IN 46107	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		4/8/12, 4/13/12,			be taken?	
	5/1/12, 5/2/12,	5/3/12, 5/5/12 5/7/12,				
	5/8/12, 5/9/12	(x 2), 5/11/12, and				
	6/2/12.				All residents have the potentia	al to
					be affected. In-service is	
	On the following	ng dates on the April,			scheduled for nurses on July	10,
		MAR it indicated that			2012 to review proper procedu	l l
	•	mg was given: 4/3/12,			for notifying physician of chan	ges
	•	4/10/12, 4/11/12,			in condition and the proper	nain
		12, 4/15/12, 4/16/12,			procedure for assessment of publications before and after PRN medications.	
	·	12, 4/19/12, 4/21/12,			administration.	.1011
		2, 5/8/12, 5/9/12,				
	,	•				
		12, 5/25/12, 5/26/12,				
	6/2/12, 6/5/12,	and 6/6/12.			3. What measures will be	
	<b>-</b>				put into place or what syster	nic
	_	dates on the April and			changes you will make to	
	,	ated the Pain Reliever			ensure that the deficient practice does not recur?	
	_	n: 4/2/12, 4/3/12,			practice does not recui :	
		4/10/12, 4/11/12,				
	·	12, 4/15/12, 4/16/12,				
	4/17/12, 4/18/1	12, 4/19/12, 4/21/12,			DNS/Designee will monitor the	e
	4/24/12, 5/1/12	2, 5/2/12, 5/3/12,			MAR M-F for proper	
	5/4/12, 5/5/12,	5/7/12, 5/8/12, 5/9/12,			documentation related to the	i
	5/12/12, 5/14/1	12, 5/18/12, 5/21/12,			assessment of the residents' perfore and after medication	pain
	5/22/12, 5/23/1	12, and 5/26/12.			administration and to observe	for
	, -	•			frequency of PRN medication	
	An intervention	on a care plan for			administration.	
		23/12, indicated the MD				
	·	r) was to be notified if				
	pain is unreliev	•				
	paiii is utitelle\ 	reu.			4. How will the corrective	•
	At 10.55	on 6/40/40 the DeN			action(s) be monitored to	
	•	on 6/12/12, the DoN			ensure the deficient practice will not recur, i.e., what qual	
		esident's MD had not			assurance program will be p	-
		egarding multiple uses			in place?	u.
	of the PRN me	dications and that the			piaco.	ı

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155072	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 06/13/2012
	PROVIDER OR SUPPLIER	2002 A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST I GROVE, IN 46107	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION
	pain care plan was not followed.			
	3.1-5(a)(3)		The pain management CQI tool will be utilized weekly X bimonthly X4 then quarterly thereafter. Corrective Action will be completed for complicities than 95%.	4, n Plan
			5. Date facility alleges compliance on July 11, 201	12

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155072	B. WIN	G		06/13/	2012
	PROVIDER OR SUPPLIER  GROVE MEADOWS		1	2002 AL	ADDRESS, CITY, STATE, ZIP CODE BANY ST GROVE, IN 46107		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
F0166 SS=D	483.10(f)(2) RIGHT TO PRODE RESOLVE GRIE A resident has the facility to resident have, include behavior of other Based on obse	MPT EFFORTS TO VANCES the right to prompt efforts by blve grievances the resident ling those with respect to the	F01	66	F166 Right to Prompt Efforts to Resolving Grievances	3	07/11/2012
	take action in re missing clothing reviewed from	esponse to a report of g for 1 of 3 residents the sample of 3 who for personal property.			It is the practice of the facility to provide a resident a prompeffort by the facility to resolv grievances the resident may have, including those with respect to the behavior of other sidents	ot e ner	
	on 6/6/12 at 10 earlier in the cuher slacks, sho missing, was state reported it Director at the that particular S	view with Resident #66 :22 a.m., she indicated irrent year, some of rts and a blouse went ill missing, and that to the Social Services time. She indicated Social Services ger worked at the			1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?  Resident #66 has had clothing items replaced.	Se I	
	During an inter Admissions Dir 1:00 p.m., she staff person res investigating m there was no in	ector on 6/11/12 at indicated she was the			2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action w be taken?		

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Event ID: 2YWV11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155072	B. WIN			06/13/2012
NAME OF B	ADOLUDED OD GLIDDLIED			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	-		2002 AI	LBANY ST	
	GROVE MEADOWS				GROVE, IN 46107	
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	,	DATE
		begin an investigation			All residents have the potentia be affected. An audit of the fac	l l
	for it.				care/ concern log for outstandi	
					items was conducted. Any	
	During another				outstanding items were	
		n 6/12/12 at 10:38			addressed within forty-eight	
	•	ated she was certain			hours.	
	•	e missing clothing to	1			
	•	ocial Services Director				
		e ever followed up with			3. What measures will be	
		sing clothing. She			put into place or what systen	nic
	stated "I never	heard anything more			changes you will make to	
	about it. They	were just gone."			ensure that the deficient	
					practice does not recur?	
	The 2/27/12 MI	DS (Minimum Data				
	Set) assessme	nt for Resident #66				
	was reviewed o	on 6/12/12 at 11:00			All care/concern items derived	
	a.m. The BIMS	6 (Brief Interview for			from the daily customer care	
	Mental Status)	score for Resident #66			rounds and monthly customer	h-a
	was 15 (highes	t possible score			care calls will be recorded on t care/concern log and then	ne
	indicating the re	esident was cognitively			channeled to the appropriate	
	intact).				department for appropriate act	ion
	,				and investigation. The Guest	
	During another	interview with the			Relations Coordinator or	
	_	ector on 6/12/12 at			designee will collect the grieva forms and distribute them to the	
		e indicated what she			appropriate Department Head.	
		nave happened, given	1		That Department Head or	
		al status of Resident			designee will investigate and	
		ne previous Social			follow up with the resident, fan	-
		or never passed the			staff or other persons involved	in
		rding the missing			the grievance, and that information will be included in	the
	clothing onto he				response section of the form.	
	_	She indicated she just			The Department Head will	
		ought Resident #66			investigate the grievance withi	
		replace her missing			24 hours of receipt and will ret	urn
	_	hen raised three	1		to the Guest Relations Coordinator. The Guest	
	i Gouiniy. She t	ווכוו ומוסכט נוווככ	1		Coordinator. The Guest	

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Event ID: 2YWV11

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	OF CORRECTION  IDENTIFICATION NUMBER:  155072	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/13/2012
	PROVIDER OR SUPPLIER  GROVE MEADOWS	2002 A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST I GROVE, IN 46107	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	department store bags full of clothing. At this time, three department store bags full of clothing were observed.  3.1-7(a)(2)		Relations Coordinator will coordinate the process to ensappropriate follow up occurs. Guest Relations Coordinator forward the grievance to the Executive Director. After the Executive Director has read a signed acknowledgement of receipt, the Guest Relations Coordinator will contact the resident and/or family to ensusatisfaction with the results of investigation. Grievances will completed within 48 hours of receipt. Grievances are discussed during the morning meeting with Department Hea An in-service is scheduled for July 10, 2012 for the nursing and Department Heads on the grievance process.	The will  and  ure f the I be  dads. f staff
			4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be prin place?  The Grievance Resolution CC audit tool will be utilized week X4, bimonthly X4 then quarte thereafter. Corrective Action will be completed for complial less than 95%.	e lity out QI kly rly Plan

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PRINTED: 07/09/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:  155072	A. BUILDING  B. WING	00	COMPLETED 06/13/2012		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE			
BEECH G	GROVE MEADOWS	}	2002 ALBANY ST BEECH GROVE, IN 46107				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	5. Date facility alleges compliance on July 11, 2012.			

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Facility ID: 000029

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155072	B. WING		06/13/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	₹			
DEECH (	GROVE MEADOWS	3		LBANY ST I GROVE, IN 46107	
BEECH	SKOVE WEADOW	3	BEECH	I GROVE, IN 40107	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0225	483.13(c)(1)(ii)-(				
SS=D	INVESTIGATE/I				
	ALLEGATIONS				
		not employ individuals who			
		d guilty of abusing,			
		istreating residents by a court nad a finding entered into the			
		e registry concerning abuse,			
		tment of residents or			
	_	n of their property; and report			
		t has of actions by a court of			
	law against an e	mployee, which would			
		s for service as a nurse aide			
		staff to the State nurse aide			
	registry or licens	sing authorities.			
	violations involviabuse, including and misappropri reported immedithe facility and to with State law the procedures (including to the facility must alleged violation and must prever while the investi  The results of al reported to the adesignated reprofficials in accordincluding to the agency) within 5	t ensure that all alleged ing mistreatment, neglect, or injuries of unknown source ation of resident property are itately to the administrator of to other officials in accordance arough established uding to the State survey and incy).  It have evidence that all is are thoroughly investigated, in further potential abuse gation is in progress.  I investigations must be administrator or his esentative and to other dance with State law  State survey and certification is working days of the incident, individuals in the control of			
	appropriate corr	ective action must be taken.			
	Based on inter	view and record	F0225		07/11/2012
	review, the fac	ility failed to ensure		F225 Investigate/Report Allegations/Investigations	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLI	ETED
		155072	B. WIN			06/13/	2012
			J. (11)		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R.			LBANY ST		
BEECH (	GROVE MEADOWS	3		BEECH GROVE, IN 46107			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	<b>†</b>	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	ons were thoroughly			It is the prestice of this facili		
	_	id failed to ensure			It is the practice of this facili to investigate all alleged	ty	
		sidents during the			violations involving		
	initial investiga	tion for 1 of 2 residents			mistreatment, neglect, or		
	that triggered for	or possible abuse			abuse, including injuries of		
	allegations. (R	esident #156)			unknown source and		
					misappropriation of resident	:	
	Findings includ	e:			property are reported		
					immediately to the		
	In an interview	with Resident #156 on			administrator of the facility a		
	6/6/12 at 11:34	a.m., the resident			to other officials in accordar with State law through	ice	
		several staff members			established procedures.		
		er. The resident gave			cotabiletieu procedures		
		ils on the allegation.			1. What corrective action	(s)	
		no on the anegation.			will be accomplished for tho	se	
	The above was	reported to the DoN			residents found to have been	n	
		rsing) on 6/6/12 at 1:10			affected by the deficient		
	,	indicated that she was			practice?		
	•						
		staff allegations of					
		rbal/mental abuse			Resident was interviewed rela	ited	
	allegations reg	arding Resident #156.			to the allegation and the		
	0 0/0/10 / /	50 " 5 "			allegation was reported to the		
		50 p.m., the DoN			ISDH. Named staff was educa	ated	
	indicated that s	-			on the resident's specific		
	Resident #156				communication and approach needs.		
	approximately	6:00 p.m., and			necus.		
		indicated that certain					
	staff members	were rude in their					
	actions, which	included CNA #6, CNA			2. How will you identify		
	#7, and LPN #8	3. The DoN also			other residents having the		
	indicated that t	he investigation started			potential to be affected by		
	at that time.	-			these same deficient practic and what corrective action w		
					be taken?	,,,,,	
	The DoN provi	ded a summary of her			~ witon		
		CNA #6. CNA #7. and					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLI	ETED
		155072	B. WIN			06/13/2	2012
CE OF P				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L		2002 AI	LBANY ST		
BEECH (	GROVE MEADOWS	3	BEECH GROVE, IN 46107				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		1/12 at 3:30 p.m. In			All residents have the potentia	l to	
		rovided, it indicated			be affected. Abuse in-servicing		
		156 thought some of			was immediately initiated upor		
		ers were rude to her.			notification of the allegation.		
		was unable to provide			In-service for staff is scheduled	d	
	specific details	of LPN #8's behavior,			for July 10, 2012 on abuse		
	but Resident #	156 indicated that LPN			prevention and the facility's ab reporting policy and procedure		
	#8, "does not s	eem too happy to be			will be discussed.		
	here helping m	e." Resident #156					
	also indicated t	hat CNA #6, "bosses					
	me around." W	/hen Resident #156					
	was asked spe	cifically how she is			3. What measures will be	_	
		by CNA #6, Resident			put into place or what system	nic	
		that CNA #6 tells her			changes you will make to ensure that the deficient		
	to clean off her	bedside table for her			practice does not recur?		
	meal. 20 to 30	minutes prior to meal			practice accometrical r		
		on the summary of the					
		dent #156 indicated					
		st comes into her room			All abuse allegations moving		
		er with her meal tray,			forward will be investigated an facility abuse policy will be	a	
		#156 cleans off her			followed. Any named staff in the	ne.	
	bedside table.				allegation will be suspended		
		he DoN interviewed			immediately pending results of		
		/12 (no time indicated).			the investigation per facility po	-	
		terviewed on 6/8/12			Abuse allegation reporting to the		
		ted) and LPN #8 was			ISDH will be initiated within 24 hours of notification of allegation		
	,	6/8/12 (no time			per facility policy.	J. 10	
		o on her summary, the					
	DoN included t	<b>.</b> .					
		ne education that was					
					4. How will the corrective		
	i biovided to the	above staff members.			action(s) be monitored to ensure the deficient practice		
	The Above D	hibition Deposition			will not recur, i.e., what quali	tv	
		hibition, Reporting,			assurance program will be pu	-	
	and Investigation	-			in place?		
	Procedure, dat	ed 2/10, was received			-		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	ULTIPLE CO	NSTRUCTION	(X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	A. BUILDING		COMPLET	
		155072	B. WIN			06/13/20	012
NAME OF P	DOMNED OF GUIDNI 155		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	<b>C</b>		2002 AL	_BANY ST		
	GROVE MEADOWS		BEECH GROVE, IN 46107				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (	COMPLETION DATE
IAU		· · · · · · · · · · · · · · · · · · ·	-	IAU	SER TOTERNOT )		DATE
		1:00 a.m., from the					
		The policy indicated					
	•	nember implicated in			The Abuse CQI audit tool will		
	_	use will be removed			utilized weekly X4, bimonthly	X4	
		at once and will			then quarterly thereafter. Corrective Action Plan will be		
	remain suspen				completed for compliance less	,	
	investigation is	completed.			than 95%.		
	On a summary	of CNA #6, CNA #7,					
		schedules, provided by					
		2/12 at 2:30 p.m., it			5. Date facility alleges		
		CNA #6 worked 6/7/12,			compliance on July 11, 2012	.	
		/12. The schedule					
	•	ated that CNA #7					
	_	and 6/9/12. LPN #8					
	worked on 6/7/	12 and 6/9/12, as					
		e summary of worked					
	schedules.	•					
	Δt 11·10 a m	on 6/12/12, the DoN					
	· ·	she did not interview					
		ents or staff members					
	,	e staff members to					
		eir behavior was a					
		y other resident or staff					
	•	essed the "rude"					
		licated by Resident					
		will interview residents					
	•	is any type of an					
		DoN also indicated					
	_	ewed CNA #6 and					
	•	they were at work on //12, respectively.					
	0/1/12 aliu 0/8/	12, respectively.					
	On 6/12/12 at 1	12:55 p.m., the DoN					

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	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 155072	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 06/13/2012
	PROVIDER OR SUPPLIER  GROVE MEADOWS	2002 AI	ADDRESS, CITY, STATE, ZIP CODE LBANY ST GROVE, IN 46107	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION
	indicated that she didn't feel the allegations Resident #156 indicated were abuse, because Resident #156 indicated that CNA #6, CNA #7, and LPN #8 actions were rude, not their voice or tone. The DoN indicated that she would not want to be treated the way Resident #156 was treated. The DoN also indicated again that she was unsure if any resident interviews were completed for the investigation. She thought the Regional Social Services Consultant interviewed residents during their investigation, but the DoN was unsure. The DoN indicated that she does know the facility policy and knows that other residents are supposed to be interviewed. The Regional Social Services interviews were requested at this time.  The Abuse Prohibition, Reporting, and Investigation Policy and Procedure also indicated that an investigation will be done to assure other residents have not been affected by the incident or inappropriate behavior and the results will be documented. The investigation will include facts and observations by witnessing non-employees and others who might have pertinent information.			

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f i			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155072	B. WIN			06/13/	ZU 1Z
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DEFOLIC					LBANY ST		
BEECH (	GROVE MEADOWS			BEECH	GROVE, IN 46107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	During an inter						
	· ·	on 6/12/12 at 1:35					
	p.m., he indicat						
		ocess, when an					
	_	appropriate behavior is					
	•	les interviewing the					
		iewing the implicated					
	•	), and interviewing					
		nbers and residents to					
		allegation happened					
	•	pattern of inappropriate					
		Administrator also					
		e would not like to be					
		same way as Resident					
		ne can see how					
		e a form of abuse. He					
		hat he was unsure if					
	any resident int						
	•	he investigation, but					
		going to check to see					
	_	Social Services					
	Consultant did	some resident					
	interviews.						
	Om 6/40/40 =1 4	10:00 a m =================================					
		0:30 a.m., copies of					
	the Facility's So						
		other residents					
		actions by CNA #6,					
	CNA #7, and L	PN #8, were provided.					
	0.4.00/.13						
	3.1-28(d)						

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l i i			(X2) MULTIPLE CO		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED			
		155072	B. WING		06/13/2012			
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE				
			2002 ALBANY ST					
BEECH GROVE MEADOWS			BEECH GROVE, IN 46107					
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE			

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Facility ID: 000029

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155072				LDING G	ONSTRUCTION  00	(X3) DATE ( COMPL 06/13/	ETED
	PROVIDER OR SUPPLIER			2002 AI	ADDRESS, CITY, STATE, ZIP CODE LBANY ST I GROVE, IN 46107		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0226 SS=D	ETC POLICIES The facility must written policies a mistreatment, ne residents and mi property. Based on interv review, the faci policy and proc investigating al	develop and implement nd procedures that prohibit glect, and abuse of sappropriation of resident view and record lity failed to follow their edures for thoroughly legations of abuse and sidents during the	F02	26	F226 Develop/Implement Abuse/Neglect Policy It is the practice of this facilit to develop and implement	ty	07/11/2012
	investigation fo triggered for po allegations. (R Findings includ	esident #156)			written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.		
	6/6/12 at 11:34 indicated that s were rude to he no further detail	with Resident #156, on a.m., the resident everal staff members er. The resident gave is on the allegation.			1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	se	
	(Director of Nui p.m. The DoN unaware of any rudeness or ve allegations rega	reported to the DoN rsing) on 6/6/12 at 1:10 indicated that she was staff allegations of rbal/mental abuse arding Resident #156.			Resident was interviewed rela to the allegation and the allegation was reported to the ISDH. Named staff were educated on the resident's specific communication and approach needs.	ted	
	indicated that s Resident #156 approximately 6	he spoke with on 6/6/12 at			How will you identify other residents having the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			(X3) DATE SURVEY
AND PLAN	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		A DIJII	A. BUILDING 00 COMPLETER		
		155072	A. BUII B. WIN			06/13/2012
		1	b. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R			LBANY ST	
BEECH (	GROVE MEADOW	S		BEECH GROVE, IN 46107		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE
		indicated that certain			potential to be affected by	
		were rude in their			these same deficient practic	
		included CNA #6, CNA			be taken?	''''
	·	8. The DoN also				
	indicated that t	the investigation started				
	at that time.					
					All residents have the potentia	
	The DoN provi	ded a summary of her			be affected. Abuse in-servicin was immediately initiated upo	
	interviews with	CNA #6, CNA #7, and			notification of the allegation.	"
	LPN #8 on 6/1	1/12 at 3:30 p.m. In			In-service for staff is schedule	d
	the summary p	provided, it indicated			for July 10, 2012 on abuse	
	that Resident #	#156 thought some of			prevention and the facility's at	
	the staff memb	ers were rude to her.			reporting policy and procedure	9
	Resident #156	was unable to provide			will be discussed.	
		of LPN #8's behavior,				
	l •	156 indicated that LPN				
	#8 "does not s	eem too happy to be			3. What measures will be	
		ne." Resident #156			put into place or what syster	nic
		that CNA #6, "bosses			changes you will make to	
		Vhen Resident #156			ensure that the deficient	
	was asked spe	ecifically how she is			practice does not recur?	
	1	I by CNA #6, Resident				
		that CNA #6 tells her				
		bedside table for her			All abuse allegations moving	
		minutes prior to meal			forward will be investigated ar	nd
		on the summary of the			facility abuse policy will be followed. Any named staff in t	he
		dent #156 indicated			allegation will be suspended	
	·	st comes into her room			immediately pending results of	f
	1	ner with her meal tray,			the investigation per facility po	
		#156 cleans off her			Abuse allegation reporting to	
	bedside table.				ISDH will be initiated within 24 hours of notification of allegation	
		the DoN interviewed			per facility policy.	0110
		7/12 (no time indicated).			F = 1 (80) Policy.	
		iterviewed on 6/8/12				
	L (110 mile maica	ted) and LPN #8 was				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	BUILDING 00		COMPLETED
		155072				06/13/2012
			B. WIN		ADDRESS SITY STATE TIP CODE	
NAME OF P	ROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE	
DEFOLL					LBANY ST	
BEECH (	GROVE MEADOWS			BEECH	I GROVE, IN 46107	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	interviewed on	6/8/12 (no time			4. How will the corrective	
	indicated) Als	o on her summary, the			action(s) be monitored to	
	DoN indicated				ensure the deficient practice	
		education that was			will not recur, i.e., what quali	ty
					assurance program will be p	ut
	provided to the	above staff members.			in place?	
		hibition, Reporting,				
	and Investigati	on Policy and			T. A. OC	. [
	Procedure, dat	ed 2/10, was received			The Abuse CQI audit tool will	
		1:00 a.m., from the			utilized weekly X4, bimonthly X then quarterly thereafter.	<sup>X4</sup>
		The policy indicated			Corrective Action Plan will be	
		nember implicated in			completed for compliance less	
	•				than 95%.	
	_	use will be removed				
		at once and will				
	remain suspen	ded until an				
	investigation is	completed.			5. Date facility alleges	
					compliance on July 11, 2012	
	On a summary	of CNA #6, CNA #7,				
		schedules, provided by				
		12/12 at 2:30 p.m., it				
		·				
		CNA #6 worked 6/7/12,				
	,	0/12. The schedule				
	1	ated that CNA #7				
		and 6/9/12. LPN #8				
	worked on 6/7/	12 and 6/9/12, as				
	indicated by the	e summary of worked				
	schedules.	-				
	Δt 11·10 a m	on 6/12/12, the DoN				
	•	she did not interview				
		lents or staff members				
		re staff members to				
	determine if the	eir behavior was a				
	pattern or if an	y other resident or staff				
	· ·	essed the "rude"				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE S COMPL		
11112 12111	or conditions	155072		LDING	<del></del>	06/13/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER	R			BANY ST		
BEECH (	GROVE MEADOWS	3		BEECH	GROVE, IN 46107		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		TE	COMPLETION
TAG		licated by Resident		TAG	DLI ICILICI I		DATE
		will interview residents					
	,	is any type of an					
		DoN also indicated					
	_	ewed CNA #6 and					
	CNA #7, while	they were at work on					
	6/7/12 and 6/8/	12, respectively.					
		12:55 p.m., the DoN					
		she didn't feel the					
	•	sident #156 indicated					
	· ·	ecause Resident #156 CNA #6, CNA #7, and					
		s were rude, not their					
		The DoN indicated that					
		want to be treated the					
	way Resident #	#156 was treated. The					
	DoN also indica	ated again that she					
	was unsure if a	any resident interviews					
	•	d for the investigation.					
	_	e Regional Social					
		ultant interviewed					
		g their investigation, as unsure. The DoN					
		she does know the					
		nd knows that other					
	residents are s						
		ne Regional Social					
		iews were requested at					
	this time.	•					
	The Ale D	hallada a Dania C					
		hibition, Reporting,					
	and Investigation	on Policy and o indicated that an					
		ill be done to assure					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155072				ULTIPLE CO LDING	NSTRUCTION 00	COMPL	ETED
		155072	B. WIN	G		06/13/	2012
	ROVIDER OR SUPPLIER			2002 AL	ADDRESS, CITY, STATE, ZIP CODE LBANY ST I GROVE, IN 46107		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	will be docume investigation with observations by non-employees have pertinent.  During an internal Administrator, op.m., he indicated investigation proported, including resident, intervistaff member(so ther staff member(so there is a perturbed that he treated as the so #156 was and I rudeness can be also indicated that he treated for the said he was if the Regional Consultant did interviews.  On 6/13/12 at 1	incident or ehavior and the results inted. The ill include facts and y witnessing and others who might information.  view with the on 6/12/12 at 1:35 and that the occess, when an appropriate behavior is des interviewing the investigation happened of attern of inappropriate Administrator also are would not like to be same way as Resident the can see how the aform of abuse. He hat he was unsure if the investigation, but going to check to see Social Services some resident.					
	the Facility's So	ocial Services					

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	OF CORRECTION	IDENTIFICATION NUMBER:  155072	(X2) MULTIPLE CO A. BUILDING B. WING	00		LETED 5/2012		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE  2002 ALBANY ST  BEECH GROVE, IN 46107					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
TAG	interviews with regarding rude	other residents actions by CNA #6, PN #8, were provided.	TAG	DEFICIENCY)		DATE		

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155072 A. BUILDING B. WING 06/	PLETED 13/2012
155072 B. WING 06/	13/2012
STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER	
BEECH GROVE MEADOWS 2002 ALBANY ST BEECH GROVE, IN 46107	
BEECH GROVE MEADOWS  BEECH GROVE, IN 46107	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE
F0241 483.15(a)	
SS=D DIGNITY AND RESPECT OF	
INDIVIDUALITY	
The facility must promote care for residents	
in a manner and in an environment that	
maintains or enhances each resident's dignity	
and respect in full recognition of his or her	
individuality.	07/11/2012
F0241	07/11/2012
Based on observation and interview,  F241 Dignity and Respect of	
the facility failed to ensure a resident Individuality	
was dressed according to his	
accustomed preferences for 1 of 1 to promote care for residents	
resident reviewed for choices.	
(Resident D) environment that maintains or enhances each resident's	
dignity and respect in full	
Findings include: recognition f his or her	
individuality.	
During an interview with Family	
Member #11, who was also Resident 1. What corrective action(s)	
D's Power of Attorney, on 6/6/12 at will be accomplished for those	
1:15 p.m., she indicated the facility residents found to have been	
did not honor Resident D's	
l practice?	
preferences on how he dressed in	
that he wore mismatched clothing and	
no shoes.	
Resident's care sheet was	
An observation of Resident D was updated to reflect family's	
made on 6/12/12 at 10:32 a.m. The	
resident was in an activity sitting in his  Customer Service representative identified and removed clothing	
Broda chair. Resident D was wearing items found to be in disrepair	
a pair of faded, flavy blue Sweat pairts	
with dried, crusted food residue on with resident's daughter, who	
the left knee area, a white undershirt, lives out of state, during her next	
and white socks with no shoes. visit to review clothing	
preferences and ensure	

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Event ID: 2YWV11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3)			3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			COMPLETED	
		155072	B. WIN			06/13/2012	
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			LBANY ST		
BEECH (	GROVE MEADOWS	3			I GROVE, IN 46107		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
		rvation of Resident D			availability of preferred clothing items.	g	
		6/13/12 at 10:05 a.m.,			items.		
		his Broda chair in an					
	activity. He wa	as observed wearing					
	black warm-up	pants, a white			2. How will you identify		
	undershirt, whi	te socks, and was			other residents having the		
	wearing gym s	hoes.			potential to be affected by		
					these same deficient practice		
	During a teleph	none interview with			and what corrective action w be taken?	1111	
	Family Membe	r #11 on 6/13/12 at			be taken?		
		e indicated Resident D					
	would always v	vear casual clothes,					
		t or dress shirt with			All residents have the potentia	•	
	trousers or kha				be affected. All staff in-servicir	•	
		ought him these types			on Dignity is scheduled for Jul	У	
		ovember, 2011. She			10, 2012.		
		oought about 6 outfits,					
		vardrobe." When told					
		D was observed			3. What measures will be		
		ay and the previous			put into place or what systen	nic	
	1	ited he would never			changes you will make to		
					ensure that the deficient		
		ndershirt, would want to , and would not wear			practice does not recur?		
	<u>-</u>	warm up pants. At					
		servation of Resident			During weekly customer care		
		made while Family			rounds and monthly customer		
		as on the telephone.			care calls to POA's/families	<b>100</b>	
		wardrobe were several			customer service representative will inquire if clothing preference		
	_	rts and polos, 3 white			have been honored and if it is		
		ındershirts, 1 orange			found that any preferences ha	ve	
		f blue and white			not been honored that informa	tion	
		2 faded maroon			will be submitted as a grievand	•	
	sweats with ho	les near the pocket			and followed up on through the	e	
	area, and blue	shorts. Family			grievance process.		
	Member #11 in	dicated, "My father					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155072	B. WIN			06/13/2012
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP CODE	
BEECH (	GROVE MEADOWS	6			_BANY ST GROVE, IN 46107	
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	does not wear	shorts. I have no idea				
	where those ca	ame from. His summer			A 11	
	clothes should	be hanging, not			4. How will the corrective action(s) be monitored to	
	winter." A clea	r garbage bag full of			ensure the deficient practice	<b>.</b>
		sting on the bottom of			will not recur, i.e., what qual	
	the wardrobe.				assurance program will be p	ut
					in place?	
		of Resident D's closet				
		the DON (Director of				
	J 7	13/12 at 1:30 p.m.			A customer service audit tool	
	_	ervation, the clear			be utilized weekly X4, bimontl	nly
	,	f clothing was opened			X4 then quarterly thereafter. Corrective Action Plan will be	
		short sleeve polo			completed for compliance less	S
		ore short sleeved			than 95%.	
	,	ite undershirts). The				
		she did not know why				
	_	nes was just lying in			5. Date facility alleges	
	there and that	<u> </u>			compliance on July 11, 2012	
	Customer servi	ce to put them away.				
	An interview wi	th CNA #12 was				
	conducted on 6	6/13/12 at 1:40 p.m.				
	She indicated s	she asked Resident D				
	what he wante	d to wear that morning				
		his head yes to the				
		rt. At this time another				
		Resident D's closet				
		IA #12 pointed out the				
		ered for Resident D to				
		e white undershirt.				
	1	g sleeve, flannel shirt.				
		a long sleeve collared				
		erature that day,				
	6/13/12, reache	•				
	degrees in Indi	anapolis, Indiana				

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER:  155072	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE COMPI <b>06/13</b>	
	ROVIDER OR SUPPLIER  GROVE MEADOWS	2002 AI	ADDRESS, CITY, STATE, ZIP COI LBANY ST I GROVE, IN 46107	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	according to weather.com.				
	This federal tag relates to Complaint IN00108327.				
	3.1-3(t)				

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Event ID: 2YWV11

Facility ID: 000029

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ	E CONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED	
		155072	A. BUILDING B. WING		06/13/2012
			_	EET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R		2 ALBANY ST	
BEECH (	GROVE MEADOWS	S	BEE	ECH GROVE, IN 46107	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	,	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	COMPLETION DATE
F0253	483.15(h)(2)	CLSC IDENTIFTING INFORMATION)	TAG	BEI I CLERKE 1 )	DATE
SS=D	HOUSEKEEPIN SERVICES	IG & MAINTENANCE			
	maintenance se	t provide housekeeping and rvices necessary to maintain rly, and comfortable interior.			
	•	ervation, interview, and	F0253		07/11/2012
		the facility failed to		F253 Housekeeping and	
		chair was clean and		Maintenance Services	
	free of stains for	or 4 of 4 random			
	observations in	nvolving Resident #2.			
				It is the practice of this	
	Findings include	de:		facility to provide	
				housekeeping and	
	On 6/6/12 at 1	2:04 p.m., Resident		maintenance services	
	#2's gerichair \	was observed with		necessary to maintain a	
	multiple whitish	n-tan stains/spots on		sanitary, orderly and	
	both geri-chair	arms. The		comfortable interior.	
	stains/spots ra	nged from about dime			
	size to about ri	ice size.			
	#2's gerichair a	on 6/7/12, Resident arms were observed stains/spots as		What corrective action will be accomplished for tho residents found to have bee affected by the deficient	se
	described abov	•		practice?	
	Resident #2's observed, on M	geri-chair was Monday, 6/11/12 at 2:05		Resident's chair was cleaned	and
	p.m., with the	-		a resident equipment cleaning	
	described as a	•		event has been scheduled for July 9, 2012.	
	ON 6/13/12 at	1:40 p.m., Resident			
	#2's geri-chair	was observed with the			
	same stains/sp	oots as described as		2. How will you identify	
	above on both	arms.		other residents having the potential to be affected by	

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Event ID: 2YWV11

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	T OF DEFICIENCIES  OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072	(X2) MU A. BUII B. WIN	LDING	onstruction 00	(X3) DATE S COMPLI 06/13/	ETED
	ROVIDER OR SUPPLIER			2002 AL	ADDRESS, CITY, STATE, ZIP CODE LBANY ST GROVE, IN 46107		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	cleaning list in	A/C Hall wheelchair dicated that Resident was to be cleaned on 2.			these same deficient practice and what corrective action w be taken?		
	on 6/13/12 at 1 that all wheelch are to be clean	with the Administrator :45 p.m., he indicated nairs and geri-chairs ed by the night shift I nursing assistant),			All residents who use wheelch for mobility have the potential be affected.		
	according to the The Administra when geri-chair cleaned they are	e schedule provided.  Itor also indicated that  Its and wheelchairs are  Ite taken to the shower  Ite and wiped down.			3. What measures will be put into place or what system changes you will make to ensure that the deficient practice does not recur?		
	3.1-19(f)				A cleaning schedule has been implemented for weekly cleani of resident personal equipmen	ing	
					4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quali assurance program will be pin place?	ty	
					DNS/Designee will audit for completion of the cleaning as scheduled weekly X4, bimonth X4 then quarterly thereafter. Corrective Action Plan will be completed for compliance less		

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		IDENTIFICATION NUMBER:  155072	A. BUILDING  B. WING	00	COMPLETED 06/13/2012			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST					
BEECH (	GROVE MEADOWS	1		I GROVE, IN 46107				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				than 95%.				
				5. Date facility alleges compliance on July 11, 2012				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CO.	NSTRUCTION	(X3) DATE : COMPL		
ANDILAN	or correction	155072	A. BUILD	ING	00	06/13/	
		133072	B. WING				
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
BEECH (	GROVE MEADOWS	3			LBANY ST GROVE, IN 46107		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PF	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0278	483.20(g) - (j)						
SS=A	ASSESSMENT	ODDINATION/CEDITIED					
		ORDINATION/CERTIFIED must accurately reflect the					
	resident's status.						
	-	se must conduct or					
		assessment with the					
	appropriate parti professionals.	cipation of health					
	professionals.						
	A registered nurs	se must sign and certify that					
	the assessment	is completed.					
	Faab individual u	ula accomplata a martina of					
		vho completes a portion of must sign and certify the					
		portion of the assessment.					
		and Medicaid, an individual					
	_	knowingly certifies a material					
		ent in a resident assessment					
	-	vil money penalty of not more each assessment; or an					
		illfully and knowingly causes					
		al to certify a material and					
		n a resident assessment is					
		money penalty of not more					
	than \$5,000 for e	each assessment.					
	Clinical disagree material and fals	ment does not constitute a e statement.					
	Based on interv	view and record	F0278	3			07/11/2012
		lity failed to document			F278 Assessment Accurac	<b>с</b> у	
		nation on the MDS for					
		ts reviewed for MDS					
		Set) accuracy.			late discount of the		
	(Resident A)	,			It is the practice of this		
	(100.00.00				facility		
	Findings includ	e:					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155072	B. WIN			06/13/2012
	PROVIDER OR SUPPLIER		•	2002 A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST I GROVE, IN 46107	
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	1	ID	1	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
	reviewed 6/8/12 The diagnoses included, but w compression from				What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	se
	MDS (Minimum	arterly Review of the nata Set) indicated add not receive PRN in medication.			The MDSC transmitted a modification to the MDS on 6/11/12	
	the following Pl medications: Acetaminopher tablets by mout	cian's Orders included RN (as needed) pain a 325 mg (milligram), 2 th, every 6 hours, for apperature greater than			2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action w be taken?	
	every 4 hours, Pain Reliever F indicated), 1 ta	ng, 1 tablet to be given for headache. Plus (no dosage blet is to be taken by hours, for headaches.			All residents have the potent to be effected	ial
	Record (MAR) back side of the documentation medications:	cation Administration was reviewed and the MAR included the of the following PRN indicated), ibuprofen			3. What measures will be put into place or what systen changes you will make to ensure that the deficient practice does not recur?	
	(400 mg) was g a headache.	given for a complaint of inophen (650 mg), was			The MDSC and MDSCA will alternate all MDS assessmen assignments which will allow	

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	OF CORRECTION IDENTIFICATION NUMBER:  155072	A. BUILDING  B. WING	COMPLETED 06/13/2012
	PROVIDER OR SUPPLIER  GROVE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	given for a complaint of pain in Resident A's back and a headache. 4/7/12, ibuprofen 400 mg, was given at 11:00 a.m. and again at 3:00 p.m., for a complaint of back pain. 4/7/12 at 8:30 a.m., Pain Reliever Plus was given for a compliant of a headache.  On 6/11/12 at 10:15 a.m., the MDS coordinator indicated that the look back period for the MDS review was 7 days prior to 4/9/12. She also indicated that headaches are considered pain and that the MDS answer, with no PRN pain medication given, was incorrect.  3.1-31(d)	them to audit each other's completed work for accura which will allow for a secon check of each MDS before transmission  4. How the corrective action(s) will be monitored ensure the deficient practic will not recur, i.e., what qua assurance program will be into place?  RAI consultant/ED designe will conduct a monthly MDS audit for accuracy  5. The facility alleges d of compliance on July 11, 2	to ee ellity put

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155072	B. WIN	G		06/13/	2012
	ROVIDER OR SUPPLIER			2002 AL	ADDRESS, CITY, STATE, ZIP CODE LBANY ST GROVE, IN 46107		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0280 SS=D	483.20(d)(3), 483 RIGHT TO PART CARE-REVISE OF The resident has incompetent or or incapacitated uniparticipate in plan changes in care  A comprehensive developed within of the comprehensive developed within of the comprehension by an interdisciple attending physicic responsibility for appropriate staff by the resident's practicable, the participate the resident's far representative; a revised by a tear each assessment Based on obset and interview, the ensure care plate prevention, and for 2 of 43 resident fo	3.10(k)(2) FICIPATE PLANNING CP In the right, unless adjudged of the right, unless adjudged of the right, unless adjudged of the laws of the State, to onling care and treatment or and treatment.  In care plan must be in 7 days after the completion of the resident, and other in disciplines as determined of the resident, and other in disciplines as determined of the resident, and periodically reviewed and of qualified persons after int.  In the facility failed to the facility fai	F02		F280 Participate in Planning And Revising Care Plan  It is the practice of this facility for the resident to participate planning care and treatment changes in care and treatment changes	y in or nt. (s)	07/11/2012
		uded but were not			-		
		deficiency anemia,					
		eimer's disease,			Dath and dautal and day	_	
	•	renous thrombosis			Both residents' care plans wer reviewed and updated for appropriateness and	е	

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R/SUPPLIER/CLIA (X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
ION NUMBER:	JILDING	00	COMPLETED
			06/13/2012
		DDRESS, CITY, STATE, ZIP CODE	
	2002 AL	BANY ST	
DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
ERCEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
'ING INFORMATION)	TAG	,	DATE
		effectiveness of interventions.	
ential for skin rebral e), anemia, el nt refuses skin ated e in bed at proaches resident with er each		2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action wibe taken.  All residents have the potential be affected.	ill
A to do skin otify LN rmals. ered. neal/ fluid r attress on assessment. ast every 2		3. What measures will be put into place or what system changes you will make to ensure that the deficient practice does not recur?  New orders and fall interventio will be reviewed in the clinical meetings and will be added to	
d). Weekly		residents' care plans. In-service on plan of care updating is scheduled for July 10, 2012.	ing
e 2 pressure heel v 0.7 by 0.4 d/ treatment		4. How will the corrective action(s) be monitored to ensure the deficient practice	
		A. BUILDING B. WING  STREET A 2002 AL BEECH  PREFIX ZING INFORMATION)  2011, Pential for skin Pebral Pential for skin Pebral Pential for skin Petrol Peroches Perice de de in bed at Proproaches Perice de in bed at Proproach	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107  PREFIX TAG  PREVIDERS PLANOF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIAT DEPICIENCY)  effectiveness of interventions.  2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken.  All residents have the potentia be affected.  e in bed at proaches esident with er each A to do skin otiffy LN trmals. ered. heal/ fluid r  attress on assessment. ast every 2 d). Weekly  All residents have the potentia be affected.  New orders and fall interventio will be reviewed in the clinical meetings and will be added to residents' care plans. In-servic on plan of care updating is scheduled for July 10, 2012.  4. How will the corrective action(s) be monitored to

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155072	B. WIN			06/13/2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
BEECH (	GROVE MEADOWS	3			LBANY ST GROVE, IN 46107	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		,		TAG	assurance program will be p	DATE
		he ADON (Assistant ses) on 6/11/2012 at			in place?	ut
		eated the 5/23/2012			•	
	•	garding the stage 2				
	_	to the resident's right			The Care Plan Updating CQI	
	•	st time it was found			audit tool will be utilized weekl	у
		was currently healing			X4, bimonthly X4 then quarter	
	and improving.	, ,			thereafter. Corrective Action F	
					will be completed for complian less than 95%.	
		Resident #C's wound				
	on 6/12/2012 a	t 10:44 a.m., while the				
	resident was si	• .			Date facility alleges complian	nce
		er room indicated the			on July 11, 2012.	
		her right outer heel. It				
		a pencil eraser and				
		The wound had no				
	_	Iness surrounding the				
	ussue. The wor	und was open to air.				
	Review of a tre	atment administration				
	record, dated 5	/25/2012, indicated,				
	"Clean right he	el area with dermal				
	wound cleanse	r then apply fluffed				
		rogel to wound base,				
	, ,	gauze-secure with				
	_	daily/ as needed with				
	soilage or displ	acement."				
	The care plan v	was not updated to				
		tment of the pressure				
	ulcer.	•				
	2 The clinical	record for Resident				
		wed on 6/7/12 at 3:30				
	p.m.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155072		(X2) MULT A. BUILDIN B. WING		NSTRUCTION  00	(X3) DATE S COMPL 06/13/	ETED	
NAME OF I	PROVIDER OR SUPPLIE	2			DDRESS, CITY, STATE, ZIP CODE		
BEECH (	GROVE MEADOWS	3			BANY ST GROVE, IN 46107		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	The diagnoses included, but we dementia unspective heat and intervention dated 5/29/12, safety helmet we the resident was buring an obsective heat and he was not helmet.  In an interview Therapist) #3, she indicated to suppose to be while he is in heat years and he was not helmet.  In an interview Therapist) #3, she indicated to suppose to be while he is in heat years and he pleases that she will not care plan need regards to the non-compliant intervention.  At 1:20 p.m. or #174's family residue to the pleases to the non-compliant intervention.	a for Resident #174 were not limited to: becified, with behavior hypertension, and art failure.  In on a fall care plan, indicated a protective was to be utilized while as up in a wheelchair.  Bervation of Resident 2 at 9:30 a.m., he was air in the dining room at wearing his protective  With PT (Physical on 6/8/12 at 1:00 p.m., hat the resident is be wearing his helmet his wheelchair, but he is colliant and will take it off She also indicated betify nursing that the als to be revised, in resident being with the fall  In 6/8/12, Resident member indicated the					
		i't always wear his n his wheelchair and					

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 155072	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMPI 06/13	LETED
	ROVIDER OR SUPPLIER GROVE MEADOWS	STREET . 2002 A	ADDRESS, CITY, STATE, ZIP C LBANY ST I GROVE, IN 46107	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	that staff don't always put it on him when he is up in the wheelchair.				
	On 6/8/12 at 2:25 p.m., the resident was up in his wheelchair eating lunch. The resident was not wearing his helmet.				
	The DoN (Director of Nursing) indicated on 6/11/12 at 11:30, that if an intervention on a care plan isn't working then the care plan should be revised.				
	3.1-35(d)(2)(B)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE			ΓE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLET			COMPLETED		
		155072				06/13/2012		
			B. WIN		ADDRESS OVEN STATE JID CODE		_	
NAME OF I	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE			
DEEQU.					LBANY ST			
BEECH	GROVE MEADOWS	5		BEECH	I GROVE, IN 46107			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	1	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE		
F0309 SS=E	483.25 PROVIDE CARE WELL BEING Each resident m must provide the services to attain practicable phys psychosocial we the comprehensicare. Based on interview, the faci effective pain n implemented for reviewed in a s the criteria for p (Resident A, #2 Findings included) 1. The clinical	ust receive and the facility encessary care and or maintain the highest ical, mental, and II-being, in accordance with ive assessment and plan of view and record lity failed to ensure nanagement was or 3 of 3 residents ample of 43, who met bain management 22, and #71).  e:  record for Resident A 6/8/12 at 10:30 a.m.	F03		F309 Provide Care/Service For Highest Well Being  It is the practice of this facility to provide the necessary care and service to attain or maintain the highest practicable physical, mental, and psychosocial well-being, i accordance with the comprehensive assessme	07/11/2012 es n	2	
	included, but w compression fr	ere not limited to: acture, back pain, and			and plan of care.			
	hip pain.							
	6/5/12 at 10:26 indicated that s their left hip an medication a lit	with Resident A on a.m., Resident A she was having pain in d she was given pain the earlier that day. It is unsure of what pain is given to her.			What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?  The residents were reassesse for pain and the physician was notified of the changes in	se n		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		155072	B. WIN			06/13/2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	t .		2002 AI	LBANY ST	
BEECH (	GROVE MEADOWS	3	BEECH GROVE, IN 46107			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	The April May	and June Physician's			condition. All prn pain	
		d the following PRN			medication orders will be audit	red
		in medications:			for frequency, of use, need for	
	` ' '				continued use and the present	ce
	-	n 325 mg (milligram), 2			of a current pain assessment	
	_	th, every 6 hours, for				
		nperature greater than				
	100 degrees.					
	•	mg, 1 tablet to be given				
	every 4 hours,	for headache.			2. How will you identify	
	Pain reliever plus (Excedrin) (no dosage indicated), 1 tablet is to be				other residents having the	
					potential to be affected by	
	taken by mouth every 8 hours, for				these same deficient practice	
	headaches.	•			and what corrective action w	ill
					be taken?	
	The following d	lates on the April, May,				
	and June MAR	•				
		Record), indicated that			All residents with PRN pain	
		n (650 mg) was given:			medication have the potential	to
	-				be affected. In-service is	
		4/8/12, 4/13/12,			scheduled for nurses on July 1	
		5/3/12, 5/5/12 5/7/12,		ire		
		(x 2), 5/11/12, and			for assessment of pain before	
	6/2/12.				and after PRN medication administration.	
					auministration.	
		g dates on the April,			3. What measures will be	,
	_	MAR, it indicated that			put into place or what systen	
	ibuprofen 400 r	mg was given: 4/3/12,			changes you will make to	
	4/4/12, 4/8/12,	4/10/12, 4/11/12,			ensure that the deficient	
	4/12/12, 4/13/1	2, 4/15/12, 4/16/12,			practice does not recur?	
		2, 4/19/12, 4/21/12,				
	-	, 5/8/12, 5/9/12,				
	-	2, 5/25/12, 5/26/12,			DNS/Designee will monitor the	_
	6/2/12, 6/5/12,				MAR M-F for proper	<i>'</i>
	5,2,12, 0,0,12,	and 0/0/12.			documentation related to the	
	The following d	lates on the April and			assessment of the residents' p	ain
	_	lates on the April and			before and after medication	
	iviay iviar indica	ited the Pain Reliever				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		
		155072	B. WIN	_		06/13/2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
BEECH (	GROVE MEADOWS	3	2002 ALBANY ST BEECH GROVE, IN 46107			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	administration.	DATE
		: 4/2/12, 4/3/12,			auministration.	
	l ' '	4/10/12, 4/11/12,				
	· ·	2, 4/15/12, 4/16/12, 2, 4/19/12, 4/21/12,				
	· ·	, 5/2/12, 5/3/12,			4. How will the corrective	9
	· ·	5/7/12, 5/8/12, 5/9/12,			action(s) be monitored to ensure the deficient practice	
		2, 5/18/12, 5/21/12,			will not recur, i.e., what qual	
	· ·	2, and 5/26/12.			assurance program will be p	-
		_, vv			in place?	
	In a review of the	he April, May, and				
	June Nursing N					
	front/back of the April, May and June				The pain management CQI at	
	MARs, there wa	as no indication for the			tool will be utilized weekly X4,	
	use of the PRN	pain medication			bimonthly X4 then quarterly thereafter. Corrective Action	Plan
	administered o	n the above dates.			will be completed for compliar	
	Also, there no	ore-assessment or			less than 95%.	
	l ·	nt of pain after the				
	PRN pain medi					
		n the above listed			5. Date facility alleges	
	dates.				compliance on July 11, 2012	
	la au int					
		with the DoN (Director				
	J	6/11/12 at 2:00 p.m., nat she was unable to				
		n-pharmacological ere used prior to				
		ninistration or if pain				
		prior/after the pain				
	l '	s administered on the				
	above dates.	, agrillinotorou orr tiro				
	An intervention	, on a care plan for				
		3/12, indicated the MD				
	l •	r) was to be notified if				
	pain is unreliev	•				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155072	B. WIN	_		06/13/	2012
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
DEFOLIA					BANY ST		
BEECH (	GROVE MEADOWS	)		BEECH	GROVE, IN 46107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	BEIGHNOT		DATE
	Visit Note, indicand headaches visit with Resid  The DoN indicap.m., that chroraddressed aga a Physician Te	ated on 6/12/12 at 3:30 nic pain was not in until 5/11/12, when lephone Order in x-ray was to be					
	2. The clinical #71 was review p.m.  The diagnoses included, but waortic stenosis, and neuropathy	record for Resident yed on 6/11/12 at 1:30  for Resident #71 ere not limited to: history of syncope,					
	she'd been have pain, heaviness with no relief. So the bottom of heavining.  The 11/3/11 part Resident #71 we related to decrees.	ring discomfort such as s, burning, or hurting She indicated at night, er feet were hot and in care plan indicated vas at risk for pain eased mobility and plaints of shoulder and					

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	of correction  X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:  155072	(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/13/2012		
	PROVIDER OR SUPPLIER  GROVE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION		
	arm pain.  During an interview with LPN #5 on 6/12/12 at 1:32 p.m., she indicated Resident #71 had chronic pain and little aches, maybe in her neck, if she slept wrong. She indicated she hadn't noticed any worsening pain in Resident #71. No other areas of pain were mentioned by LPN #5. When queried about any other pain Resident #71 may have, she indicated, "She would tell me if there was pain we didn't know about." At this time, the complaint of pain/burning on the bottom of Resident #71's feet was brought to the attention of LPN #5. LPN #5 indicated the resident did, in fact, inform about the pain on her feet a couple of months ago.  The 4:00 a.m., 2/9/12 nurses note was reviewed with LPN #5 and indicated, "Resident (symbol for "with") c/o (complaint of) pain to posterior aspects of bilateral feet. Areas assessed no anomalies noted. Resident states pain occurs primarily during noc (night) hours (symbol for "and") has been increasing in pain (symbol for "and") intensity over the last several weeks. Also states pain has been disrupting sleepMD (name of MD)'s office notified of					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155072	B. WIN	IG		06/13/	2012
NAME OF I	PROVIDER OR SUPPLIEF		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SUPPLIER			2002 AL	BANY ST		
BEECH (	GROVE MEADOWS	5		BEECH	GROVE, IN 46107		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		nplaints) (symbol for					
		ed to evaluate resident					
	on next rounds."						
		., 2/9/12 nurses note					
	indicated, "res						
	(continues) c/o (complaints)						
	intermittant [sic] pain to bottoms of						
	bilateral feet"						
	There was no information in the clinical record to indicate Resident						
	#71 was seen	on the next rounds					
	regarding the b	ourning on the bottom					
	of her feet.						
	LPN #5 indicat	ed she would look into					
	this further for	any follow through.					
	During an inter	view with the DON					
		rsing) on 6/13/12 at					
		e indicated the next					
	· ·	to occur after 2/9/12					
		2 and there was no					
		ndicate Resident #71					
		ne 2/10/12 round					
		pain in her feet. She					
		re was any follow					
	_	time, there was no					
		ne indicated she would					
		the doctor to see her					
		rounds. She indicated					
		vare of any system					
	1	d in place to ensure the					
	doctor's office	followed through with					

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155072	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE S COMPLE <b>06/13/2</b>	ETED
	PROVIDER OR SUPPLIER  GROVE MEADOWS	2002 AI	ADDRESS, CITY, STATE, ZIP COD LBANY ST GROVE, IN 46107	DE T	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  issues brought to their attention.	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	The 6/8/12 podiatry progress note was reviewed and indicated "Subjective: burning pain bottom of feet. History of Present Illness: admits to increasing pain bottom of feet burning in nature (symbol for greater than) 6 months duration. Pain has increased over that time frame. Gets worse @ night in bed. Notes/Orders: recommend Rx (prescription) Neurotin (medication taken for neuropathy)."  No information could be found in the clinical record to indicate the above prescription was ordered for Resident #71 until 5 days later on 6/13/12, after this issue was brought to the attention of the facility staff on 6/12/12.  The 6/13/12 physician's progress note indicated, "Foot painSays her foot pain worse at night. Shooting type painPain needs help. Assessment: Neuropathy. Plan: Start Neurotin."  Resident #71 was diagnosed with neuropathy on 6/13/12 and prescribed the podiatry recommended medication for this disease.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		155072	B. WING		06/13/2012		
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF F	PROVIDER OR SUPPLIEF	₹		LBANY ST			
	GROVE MEADOWS	_	BEECH	I GROVE, IN 46107			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	``	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
		record for Resident					
	#22 was reviewed on 6/11/12 at 1:00 p.m.						
		for Resident #22					
	l '	vere not limited to:					
		morbid obesity, and					
	degenerative jo	oint disease.					
	The June, 201						
	•	orders for Resident #22					
	indicated one 5-325 tab of						
	hydrocodone to	o be given by mouth					
	every 4 hours a	as needed for					
	moderate pain.						
	· ·	2 MAR (Medication					
		Record) for Resident					
		nydrocodone was given					
	twice on 6/12/1	12, three times on					
	6/11/12, and tv	vice on 6/8/12. There					
	was no informa	ation in the clinical					
	record to indica	ate the resident was					
	assessed for th	ne location or					
	intensity/nature	e of the pain prior to					
	administering t	he pain medication or					
	for the effective	eness of the					
	medication after	er the medication was					
	given.						
	-						
	During intervie	w with LPN #1 on					
		10 p.m., she indicated,					
		ument one time, sorry.					
		ow." She proceeded to					
	1	back of the MAR with a					

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155072	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY  TPLETED  13/2012	
	PROVIDER OR SUPPLIER  GROVE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE  2002 ALBANY ST  BEECH GROVE, IN 46107				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	6/11/12 entry for a hydrocodone administration.					
	During interview with the DON 6/12/12 at 12:52 p.m., she indicated there was no information to indicate a pre-assessment or post assessment for pain was done on the above dates. She stated, "It looks like night shift has a problem with this."  3.1-37(a)					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	e survey pleted 3/2012		
NAME OF P	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CO	ODE			
BEECH (	GROVE MEADOWS	3	2002 ALBANY ST BEECH GROVE, IN 46107					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155072		(X2) MULTIPLE C	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/13/2012	
		100072	B. WING	ADDRESS SYNV STATE SID CODE	00/10/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ALBANY ST	
BEECH (	GROVE MEADOW	5		H GROVE, IN 46107	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCI)	DATE
F0314 SS=D	483.25(c) TREATMENT/S PRESSURE SO Based on the co a resident, the fa resident who en pressure sores of sores unless the demonstrates the and a resident h receives necess promote healing prevent new sor Based on reco and observation ensure pressur related to ill-fitt residents revie ulcers. (Resident Findings includent Resident #C's reviewed on 6/ Diagnoses incl limited to; iron dementia, Alzh hypertension, v	VCS TO PREVENT/HEAL PRES of prehensive assessment of acility must ensure that a ters the facility without does not develop pressure individual's clinical condition at they were unavoidable; aving pressure sores fary treatment and services to a prevent infection and res from developing.  In the facility failed to re ulcer prevention fing shoes for 1 of 4 aved for pressure ent #C)  de:  clinical record was 8/2012 at 2:05 p.m. auded but were not deficiency anemia, reimer's disease,	F0314	F314 Treatment/Svcs To Prevent/Heal Pressure Sores  It is the practice of this facility to provide comprehensive assessme of a resident, the facility must ensure that a reside who enters the facility without pressure sores does not develop pressur sores unless the individual's clinical	07/11/2012
	A care plan, da indicated, "Pro breakdown relavascular accident decreased moincontinence, a	ated 6/22/2011, blem: Potential for skin ated to cerebral ent (stroke), anemia,		condition demonstrates the they were unavoidable; and a resident having pressure sores received necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	nd e

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r i i		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155072	B. WIN			06/13/2012
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE	
DEECH (	GROVE MEADOW	e e			LBANY ST I GROVE, IN 46107	
					GROVE, IN 40107	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	, and the second	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
1710	breakdown. Ap	*		1710		DATE
		els up while in bed at				
		in bed. Approaches			1. What corrective action	
	dated 6/22/2011; Assist resident with				will be accomplished for tho	· · · · · · · · · · · · · · · · · · ·
		eri care after each			residents found to have bee	n
	incontinent episode. CNA to do skin check with shower and notify LN (licensed nurse) of abnormals.				affected by the deficient practice?	
					practice:	
	Diet/supplements as ordered. Encourage 75 to 100% meal/ fluid					
					Appropriate fitting footwear provided for resident.	
	consumption and monitor consumption. Pressure reducing/redistribution mattress on bed. Pressure ulcer risk assessment.				provided for resident.	
					2. How will you identify	
	Turn and repos	sition at least every 2			other residents having the	
	1	(as needed). Weekly			potential to be affected by these same deficient practic	۵
	skin checks by	,			and what corrective action v	
	1				be taken?	
	Review of resid	dent progress notes				
	indicated week	dy skin assessments				
	were complete	ed on 5/9/12 at 2:24			All residents have the potential	al to
	a.m. and 5/23/	12 at 2:21 a.m. There			be affected.	
	was no assess	sment for 5/16/2012.				
	_	, dated 5/23/12 at 2:21			3. What measures will be	
	a.m., indicated	I, "Stage 2 pressure			put into place or what system	
		right outer heel			changes you will make to	
		proximately 0.7 by 0.4			ensure that the deficient	
	, ,	cian notified/ treatment			practice does not recur?	
	•	orders. Family to be				
	notified by day	shift"				
					All new admits will be assessed	ed
		the ADON (Assistant			for appropriate fitting footwear	r
		rses) on 6/11/2012 at			utilizing a Brannock device.	
	2:32 p.m., indi	cated, "weekly skin				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072		(X2) MU A. BUIL B. WINC	DING	nstruction 00	(X3) DATE S COMPLI 06/13/2	ETED	
	PROVIDER OR SUPPLIER		D. 11110	STREET A	ADDRESS, CITY, STATE, ZIP CODE BANY ST GROVE, IN 46107		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	nurses." He did were no nursing check document ADON stated, ' note regarding area to her right time it was four	expectation of the dn't know why there g notes or weekly skin anted on 5/16/2012. The l'The 5/23/2012 nursing the stage 2 pressure at heel was the first and. The wound is ag and improving."			In house residents will be assessed quarterly for appropriate fitting footwear utilizing a Brannock device.  4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quali		
	observed the w	nd not yet personally yound.  Resident #C's wound			assurance program will be prin place?	-	
	a.m., with ADO resident was in up in her whee wheelchair did attached, she had shoes, and her	6/12/2012 at 10:44 N present. The her room and sitting lchair. Resident #C's not have foot pedals had on socks with no feet were dangling. hoved her right sock			The Skin Management Progra CQI tool to be completed weel X4, bimonthly X4 then quarterl thereafter. Corrective Action F will be completed for complian less than 95%.	kly ly Plan	
	and her wound right outer heel size of a pencil color, and there redness surrou The wound was sock was put b He indicated the dressing change the early a.m. a removed the drobservation. He Resident #C basice of a pencil right of the pencil removed the drobservation.	was observed on her . The wound was the eraser and black in e was no drainage or nding the black tissue. Is left open to air until a ack on by the ADON. at the resident's les are completed in and that he had just ressing prior to the le offered to take ack to activities. The earing socks but no			5. The facility alleges date of compliance on July 11, 20		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE S COMPL		
11112 12111	or confidence.	155072		LDING		06/13/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				BANY ST		
BEECH (	GROVE MEADOWS	3		BEECH	GROVE, IN 46107		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	shoes when sh	e left the room.					
	Review of a ME 3/12/2012, indirequired extens dressing. The rinvolved in active weight bearing person physical dressing which resident puts of all items of a Transcript Review of a Transcript Review of a Transcript Record (TAR), indicated, "Clear dermal wound fluffed gauze who base, cover with with Kerlix. Chawith soilage or original MD ordicated she woriginal MD ordica	OS assessment, dated cated the resident sive assistance for esident was able to be vity, staff provided support requiring one all assistance for is defined by how the in, fastens and takes clothing.  Beatment Administration dated 5/25/2012, an right heel area with cleanser then apply with hydrogel to wound the dry gauze-secure ange daily/ as needed displacement." No ler documentation Interview with the 012 at 2:00 p.m., was unable to find the ler for the right heel					
	toes were toucl	hing the ground, but					

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NAME OF PROVIDER OR SUPPLIER  BEECH GROVE MEADOWS  SUMMARY STATEMENT OF DEFICIENCIES  PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  The middle of her feet and heels were suspended in the air.  Interview with ADON on 6/13/2012 at 11:10 a.m., indicated, "Resident #C's old shoes were what caused the pressure ulcer on her right outer heel." He considered it to be healed now since it is not causing her any discomfort, this was why he didn't redress the wound. "Resident #C has since gotten new shoes and so maybe she hasn't been wearing them because it's a possibility the CNA's don't know she has new ones. The resident ideally should be wearing these new shoes." He indicated he wasn't sure why she didn't have foot pedals on her wheelchair but he would take care of this and put her shoes on right away. He indicated he didn't think her not wearing shoes would cause any concern for her skin integrity on her feet."	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE		
NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS  X4) ID SUMMARY STATEMENT OF DEFICIENCIES TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  THE MIDDLE OF THE APPROPRIATE THE APPROPRIATE TO COMPLETION DATE  STRIET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107  (XS) TO MIDDLE OF THE APPROPRIATE THE APPROPRIATE THE APPROPRIATE THE MIDDLE OF THE APPROPRIATE THE APPROPRIATE TO COMPLETION DATE  (XS) TO COMPLETION THE PREFIX TAG  THE MIDDLE OF THE APPROPRIATE THE APPROPRIATE THE APPROPRIATE THE MIDDLE OF THE APPROPRIATE THE APPROPRIATE THE APPROPRIATE TO COMPLETION TO COMPLETION THE APPROPRIATE THE APPROPRIATE TO COMPLETION TO COMPLETION THE APPROPRIATE THE APPROPRIATE THE MIDDLE OF THE APPROPRIATE THE APPROPRIATE THE APPROPRIATE THE MIDDLE OF THE APPROPRIATE THE	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		
BEECH GROVE MEADOWS  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (PERTITY TAG PREFIX TAG PROPERLY MIST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  The middle of her feet and heels were suspended in the air.  Interview with ADON on 6/13/2012 at 11:10 a.m., indicated, "Resident #C's old shoes were what caused the pressure ulcer on her right outer heel." He considered it to be healed now since it is not causing her any discomfort, this was why he didn't redress the wound. "Resident #C has since gotten new shoes and so maybe she hasn't been wearing them because it's a possibility the CNA's don't know she has new ones. The resident ideally should be wearing these new shoes." He indicated he wasn't sure why she didn't have foot pedals on her wheelchair but he would take care of this and put her shoes on right away. He indicated he didn't think her not wearing shoes would cause any concern for her skin integrity on her feet."			155072	B. WIN	G		06/13/	2012
BEECH GROVE MEADOWS    Comparison of the content of	NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID PREFIX TAG WINTERSON TO THE PERCENCIES (EACH DEPICIENCY MUST BE PERCEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  the middle of her feet and heels were suspended in the air.  Interview with ADON on 6/13/2012 at 11:10 a.m., indicated, "Resident #C's old shoes were what caused the pressure ulcer on her right outer heel." He considered it to be healed now since it is not causing her any discomfort, this was why he didn't redress the wound. "Resident #C has since gotten new shoes and so maybe she hasn't been wearing them because it's a possibility the CNA's don't know she has new ones. The resident ideally should be wearing these new shoes." He indicated he wasn't sure why she didn't have foot pedals on her wheelchair but he would take care of this and put her shoes on right away. He indicated he didn't think her not wearing shoes would cause any concern for her skin integrity on her feet."								
PREFIX TAG  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)  the middle of her feet and heels were suspended in the air.  Interview with ADON on 6/13/2012 at 11:10 a.m., indicated, "Resident #C's old shoes were what caused the pressure ulcer on her right outer heel." He considered it to be healed now since it is not causing her any discomfort, this was why he didn't redress the wound. "Resident #C has since gotten new shoes and so maybe she hasn't been wearing them because it's a possibility the CNA's don't know she has new ones. The resident ideally should be wearing these new shoes." He indicated he wasn't sure why she didn't have foot pedals on her wheelchair but he would take care of this and put her shoes on right away. He indicated he didn't think her not wearing shoes would cause any concern for her skin integrity on her feet."	BEECH (	GROVE MEADOWS	5		BEECH	GROVE, IN 46107		
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Interview with ADON on 6/13/2012 at 11:10 a.m., indicated, "Resident #C's old shoes were what caused the pressure ulcer on her right outer heel." He considered it to be healed now since it is not causing her any discomfort, this was why he didn't redress the wound. "Resident #C has since gotten new shoes and so maybe she hasn't been wearing them because it's a possibility the CNA's don't know she has new ones. The resident ideally should be wearing these new shoes." He indicated he wasn't sure why she didn't have foot pedals on her wheelchair but he would take care of this and put her shoes on right away. He indicated he didn't think her not wearing shoes would cause any concern for her skin integrity on her feet."	TAG				TAG	DEFICIENCY)		DATE
Interview with ADON on 6/13/2012 at 11:10 a.m., indicated, "Resident #C's old shoes were what caused the pressure ulcer on her right outer heel." He considered it to be healed now since it is not causing her any discomfort, this was why he didn't redress the wound. "Resident #C has since gotten new shoes and so maybe she hasn't been wearing them because it's a possibility the CNA's don't know she has new ones. The resident ideally should be wearing these new shoes." He indicated he wasn't sure why she didn't have foot pedals on her wheelchair but he would take care of this and put her shoes on right away. He indicated he didn't think her not wearing shoes would cause any concern for her skin integrity on her feet."								
11:10 a.m., indicated, "Resident #C's old shoes were what caused the pressure ulcer on her right outer heel." He considered it to be healed now since it is not causing her any discomfort, this was why he didn't redress the wound. "Resident #C has since gotten new shoes and so maybe she hasn't been wearing them because it's a possibility the CNA's don't know she has new ones. The resident ideally should be wearing these new shoes." He indicated he wasn't sure why she didn't have foot pedals on her wheelchair but he would take care of this and put her shoes on right away. He indicated he didn't think her not wearing shoes would cause any concern for her skin integrity on her feet."		suspended in t	ne air.					
The federal tag relates to Complaint IN00108327.  3.1-40(a)(1)		Interview with A 11:10 a.m., ind old shoes were pressure ulcer heel." He cons now since it is it discomfort, this redress the working gotten nemaybe she has because it's a property don't know she resident ideally these new shoek wasn't sure who pedals on her would take care shoes on right didn't think her would cause ar integrity on her.  The federal tag IN00108327.	ADON on 6/13/2012 at icated, "Resident #C's what caused the on her right outer sidered it to be healed not causing her any was why he didn't und. "Resident #C has we shoes and so on't been wearing them possibility the CNA's has new ones. The should be wearing es." He indicated he y she didn't have foot wheelchair but he e of this and put her away. He indicated he not wearing shoes by concern for her skin feet."					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM	TE SURVEY MPLETED 13/2012		
NAME OF F	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP	CODE			
BEECH (	GROVE MEADOW	'S	2002 ALBANY ST BEECH GROVE, IN 46107					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLI	ETED
		155072	B. WIN			06/13/2	2012
	OVIDER OR SUPPLIER		•	2002 AL	ADDRESS, CITY, STATE, ZIP CODE LBANY ST GROVE, IN 46107		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0329 SS=D	483.25(I) DRUG REGIMEN UNNECESSARY Each resident's of from unnecessar drug is any drug dose (including dexcessive duration monitoring; or wiffor its use; or in the consequences whould be reduced combinations of the state of th	N IS FREE FROM DRUGS drug regimen must be free y drugs. An unnecessary when used in excessive duplicate therapy); or for on; or without adequate thout adequate indications he presence of adverse hich indicate the dose and or discontinued; or any the reasons above.  The reasons above.  The reasons above assessment of a lity must ensure that the not used antipsychotic en these drugs unless g therapy is necessary to ondition as diagnosed and the clinical record; and the antipsychotic drugs dose reductions, and the entions, unless clinically in an effort to discontinue wiew and record lity failed to provide an RN (as needed) dication administration in-pharmaceutical from to anti-anxiety ininistration for 1 of 10 and for unnecessary the esident #44)	F03		F329 Drug Regimen is Free From Unnecessary Drugs  It is the practice of this facilit to provide each resident's dr regimen must be free from unnecessary drugs.  1. What corrective action will be accomplished for thos residents found to have been	ug (s) se	07/11/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED
		155072	B. WIN			06/13/2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	LBANY ST	
BEECH (	GROVE MEADOWS	3			I GROVE, IN 46107	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
	was reviewed	on 6/7/12 at 2:50 p.m.			affected by the deficient	
					practice?	
	The diagnoses	for Resident #44				
	included, but w	as not limited to:				
	anxiety, depression, and end stage renal disease.				Resident's physician was noti	fied
					regarding the frequency of use	
					PRN clonazepam for this resid	
	The April and M	May Physician's Orders				
	The April and May Physician's Orders indicated an order for a half of a					
	tablet of 0.5 mg (milligram) clonazepam (anti-anxiety medication)				2. How will you identify	
					other residents having the	
	to be taken by mouth every 12 hours PRN (as needed).				potential to be affected by	
					these same deficient practice and what corrective action w	
					be taken?	""
	An intervention	i, dated 3/22/12, on			be taken?	
	care plan for th	e use psychotropic				
	medications, in	idicated that				
	· ·	e to be administered			All residents on PRN medication	ons
	as ordered and				have the potential to be effected	
	effectiveness.	. 05001 700 101			Nurses will be in-serviced on a	luly
	Chechiveness.				10, 2012 about proper	
	The American of N	Ass. NAAD (Nasdissties			procedures for attempting	
		May MAR (Medication			non-pharmacological interventions and documentati	on
		Record) indicated that			of the interventions prior to the	
		took a half a tablet of			administration of PRN	
	0.5 mg PRN cl	onazepam on the			psychoactive medications and	
	following dates	: 4/6/12, 4/11/12,			documentation indicating the	
	4/19/12, 4/24/1	2, 5/8/12, 5/10/12,			need for medication and the	
	5/12/12, 5/16/1	2, 5/25/12, 5/26/12,			resident's response to the	
	5/29/12, and 5/				medication. They will also be	
	, ,				in-serviced on facility's new	
	There was no i	ndication, in the			procedure for calling the DNS/Designee prior to the	
		I including the Nurse's			administration of PRN	
		he front/back of the			psychoactive medications.	
		MARs, for the use of				
	the medication	for the above dates.				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155072	B. WIN			06/13/2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	₹		2002 AI	LBANY ST	
BEECH (	GROVE MEADOWS	3			I GROVE, IN 46107	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	Also there was	no indication that any			3. What measures will be	
	non-pharmacol	logical interventions			put into place or what systen	nic
	were utilized for the above dates.				changes you will make to	
					ensure that the deficient	
	On 6/0/12 at 1:	00 p.m., the DoN			practice does not recur?	
		-				
	(Director of Nursing) indicated that she was unable to determine if any					
					Audit all residents on PRN	
	-	logical interventions			medications for frequency of	
	were used or w	why the medication was			usage and need for continued	
	given on the ab	oove dates.			usage and need for continued	
	3.1-48(a)(4)				Monthly pharmacy consultant	will
					audit PRN medication usage	
					monthly.	
					DNS or designee contacted pr	ior
					to PRN psychoactive medicati	on
					administration.	
					Pain assessment completed for	or.
					all new onset pain.	ות
					·	
					All non-pharmacologic	.
					interventions will be document	ed
					prior to PRN medication	and
					administration. Indications for effectiveness of PRN medicati	
					will be documented.	OH
					bo documentou.	
					Corrective action up to and	
					including termination for staff r	not
					complying with corrective	
					measures.	
					4. How will the corrective	
					action(s) be monitored to	
					ensure the deficient practice	<b>I</b>
					will not recur, i.e., what quali	ty

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  155072		A. BUILDING B. WING	COMPLETED 06/13/2012		
	ROVIDER OR SUPPLIER		STREET A 2002 A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST I GROVE, IN 46107	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION
				assurance program will be in place?	e put
				Unnecessary Medication C to be completed weekly X4 bimonthly X4 then quarterly thereafter. Corrective Action will be completed for compless than 95%.	., y on Plan
				5. The facility alleges of compliance on July 11,	

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Event ID: 2YWV11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII	DING	00	COMPL	ETED
		155072	A. BUII B. WIN			06/13/	2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LBANY ST		
BEECH (	GROVE MEADOWS	3			GROVE, IN 46107		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0364 SS=E	provides food pre conserve nutritive appearance; and attractive, and at Based on obse the facility failed served from the palatable, attractive	EFER TEMP ceives and the facility epared by methods that e value, flavor, and I food that is palatable, the proper temperature.  rvation and interview, d to ensure food e kitchen was ctive, and served at a	F03	64	F364 Nutritive Value/Appearance, Palatable/Prefer Temp.		07/11/2012
	preferable temperature. This affected 9 of 14 residents interviewed for food quality. (Resident #177, 148, 166, 143, 83, 56, 156, 66 and 86)  Findings include:				It is the practice of this facility provide food that has a nutritive value and appearance and is palatable and at a preferred temperature		
	#148 indicated	on 6/5/12, Resident the food had no flavor e not always served at temperature.			1. What corrective action will be accomplished for thos residents found to have been affected by the deficient practice?	se	
	#143 indicated served at the p				Residents noted to be affected by the deficient practiwill be monitored for 3 random meals weekly by assigned members of the IDT.      Any identified issues will resolved promptly in accordan with dietary guidelines and ME orders.	I be ce	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3		(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIIII	LDING	00	COMPLI	ETED
		155072	B. WIN			06/13/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SUPPLIEF	<u>t</u>		2002 AI	BANY ST		
BEECH (	GROVE MEADOWS	3			GROVE, IN 46107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE		DATE
	•	w with Resident # 56					
		1:08 p.m., Resident			2. How will you identify		
	#56 indicated t	he food did not taste		other residents having the			
	good and look appetizing.				potential to be affected by		
					these same deficient practice and what corrective action w		
	Resident #166	indicated on 6/6/12 at				""	
	10:39 a.m., the	food was almost					
	always served	at the inappropriate					
	temperature.  During an interview with Resident #86				All residents who participate in	1	
					dining meal service have the		
					potential to be affected.		
	on 6/6/12 at 11:22 a.m., he indicated						
	his breakfast was always cold.						
	This breaklast w	as always cola.			3. What measures will be		
	, .				put into place or what systen changes you will make to	nic	
	_	w with Resident # 83	1 1 -		ensure that the deficient		
	on 6/6/2012 at	11:51 a.m., Resident		practice does not recur?			
	#83 indicated t	he food did not taste					
	good and look	appetizing nor was it					
	served at the p	roper temperature.			· A dining room monitorin	ın	
	He stated, "It's	ice cold."			schedule has been put into pla	•	
	,				to ensure timely meal tray		
	At 11:55 a.m	on 6/6/12, Resident			delivery, food appearance and	l	
		the meals were never			palatability.		
					· New insulated hall carts	i	
	serveu at an ap	opropriate temperature.			are being used to deliver meal		
		·			trays to the halls.		
	_	view with Resident #66			Dietary will be in-service	ed	
		:18 p.m., regarding her			on correct methods of followin		
		cated her food did not			the recipes, and correct		
	_	s not full, and was			monitoring of food holding		
	dissatisfied.				temperatures.		

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		X1) PROVIDER/SUPPLIER/CLIA	(x2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			00	COMPI	
		155072	B. WIN	IG		06/13	/2012
MANGOTT	NDOLUDED OF GURDY YES	\ .			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				2002 AI	LBANY ST		
BEECH GROVE MEADOWS			BEECH GROVE, IN 46107				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	I		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREF	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ATE	DATE
	2 A test tray v	vas observed on 6/7/12					1
	_	The tray consisted of					
	sloppy joe, pot	•			4. How the corrective		
		d. The sloppy joe			action(s) will be monitored t	0	
					ensure the deficient practice		
	tasted lukewar	m, at best.			will not recur, i.e., what qual	_	
					assurance program will be p	out	
		ray was observed on			into place?		
		p.m. The tray					
		western burger, onion					
	rings, and mixe	ed fruit. The burger and			· The Dietary Manager o	r	
	onion rings tas	ted room temperature			Designee will complete the Co		
	and bland.				Meal Service Form 5 days pe		
					week for two weeks, then three		
	3.1-21(a)(2)				times a week for 2 weeks the	n	
	( )( )				weekly for 4 weeks.		
					Test trays will be samp	led	
					weekly for eight weeks by	100	
					members of the IDT.		
					Results of these audits		
					be forwarded to the monthly (	JQI	
					Meeting.		
					5. The facility alleges da	ite	
					of compliance on July 11, 20	)12.	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072		LDING	00	(X3) DATE : COMPL <b>06/13</b> /	ETED
	PROVIDER OR SUPPLIER			2002 A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST I GROVE, IN 46107		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0465 SS=E	ABLE ENVIRON The facility must sanitary, and cor residents, staff a Based on obse the facility faile was kept in a c	provide a safe, functional, mfortable environment for and the public. ervation and interview, d to ensure the kitchen lean, sanitary condition tchen observations.	F04	65	F465 SAFE/FUNCTIONAL/SANITA COMFORTABLE ENVIRONMENT	RY/	07/11/2012
	An observation was made on 6 Upon entrance feet began to seach subseque sound of a shounderneath the mushy looking on the floors ar	of the entire kitchen 6/4/12 at 12:00 p.m. to the kitchen, one's tick to the floor with ent step, enabling the e peeling off the floor. e dishwasher area wet, debris was observed around cream The stench of old food			It is the practice of this facility provide a safe, functional, sanitary, comfortable environment.  1. What corrective action will be accomplished for tho residents found to have been affected by the deficient practice?	(s) se	
	was made on 6 quarter size glothe floor betwee crumbs and bir storage area. If lying over a pacucumber saladishwasher. A the dishwasher				The floor has been dee scrubbed on June 27, 2012. The dish machine drain was resealed to stop the leak the floor.  How will you identify		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00		(X3) DATE SURVEY COMPLETED			
		155072	B. WIN	G		06/13	/2012
NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	E	(X5) COMPLETION DATE
	crevices. The general the cream color buring an intermediated the floatest and color buring an intermediated the floatest and under the dishwasher indicated the general to the dishwasher indicated the general to the stuff underneat indicated they sand mopping endicated it was wall like it should to drip down the floor. Puddles observed restingipes under the During interview on 6/7/12 at 11	gunk remained around red pipes underneath.  View with the Dietary 7/12 at 11:30 a.m., she cors were cleaned al. She indicated her s for floors to be kitchen appliances like and stoves. She shwasher area was ay about an hour ago, but they didn't do a because she could see th on the floor. She should be sweeping very shift underneath the pointed to the metal ishwasher area where ad through and a not attached to the lid be, enabling water the wall and onto the of water were ag underneath the edishwasher.  We with Dietary Aide #10 :43 a.m., he indicated			CROSS-REFERENCED TO THE APPROF	ice will his be emic	
	breakfast, but of he could reach  During interview	dishwasher area after lid not mop as far as  w with the Dietary 7/12 at 11:40 a.m., she			assurance program will be into place?  Dietary Manager or	put	

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	of Correction identification number:  155072	A. BUILDING B. WING	COMPLETED 06/13/2012			
	ROVIDER OR SUPPLIER  GROVE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	indicated she was the one who mopped under the stove area and that she did not mop as far as she could reach.	Designee will complete 5 day per week the "Short Sanitatio Inspection" for 2 weeks and to 3 days per week for 2 weeks then weekly for 4 weeks.	n hen			
	During another interview with the Dietary Manager on 6/8/12 at 11:50 a.m., she indicated there was, in fact, a leaky pipe under the dishwasher area and that someone was coming in to fix it. She stated, "We also deep cleaned the floors. They look great."  3.1-19(f)	Results of these audits be forwarded to the monthly of Meeting.  5. The facility alleges da of compliance on July11, 20	CQI te			

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